SAVES Program
Skills for Academic Vocational and English Studies

ADDITIONAL NOTES

Student's Name _____ ID Number _____

School Name _____ Location Number _____

DATE	TERM	NOTES	INITIALS

MIAMI-DADE COUNTY PUBLIC CHOOLS
Skills for Academic, Vocational, and English Studies (SAVES)
INTAKE FORM

1. _____
Date

2. _____
Last Name, First Name

3. _____
Address **City, State, Zip Code**

4. _____
Telephone No.

5. _____
Name and Emergency Contact Number

6. **Eligibility Documents:**
(Attach Front and Back Copies of Documents)

a) USCIS Document _____

b) Date of USCIS Expiration _____

c) Alien Number _____

d) Social Security No. _____

e) Student ID No. _____

f) Other Document _____

g) _____
Port of Entry (City and State)

7. Date of Entry in USA (eligible) _____

8. Date of Birth _____

9. Male **Female**

10. Country of Origin **Cuba** **Haiti**

Other _____

11. Native Language _____

12. _____
E-mail Address

13. Marital Status: **Single** **Married**

Divorced **Widowed** **Separated**

14. _____
Number of Children

15. _____
Years of Formal Education Outside of the USA

16. _____
Professional Licenses/Area of Study

17. _____
Employment in County of Origin

18. Check one of the choices: **Employed** **Unemployed**

Employer _____

18a. List the position if employed _____

Start Date _____ **Termination Date** _____

18b. _____
Number of Working Hours per Week (Full-Time/ Part-Time)

18c. Are you self-employed? Yes No

18d. Earnings: (Hourly) $ _____ **Wages $** _____

18e. Access to Health Insurance Yes No

19. Employment Referral _____

_____

_____ _____
Student's Signature **SAVES Employee Name/Signature**

<u>Information to be Provided upon Student Exiting from Program (s):</u>

1. _____
Employer

2. Earnings: Hourly $ _____ **Wages $** _____

3. _____
Student's Current Address

4. _____ _____
Student's Current Telephone Number **Alternate Telephone Number**

<u>Completion/Termination Information</u>

1. Program Completed: Yes No Withdrawal Date _____

2. Reasons for Not Completing Program _____

_____

Disclaimer in English

By providing this electronic signature, I _____am attesting that I understand that electronic signatures are legally binding and have the same meaning as handwritten signatures. I am also confirming that internal controls have been maintained, and that policies and procedures were properly followed to ensure the authenticity of the electronic signature.

Date: _____

EXHIBIT C3 – REALEASE OF INFORMATION

INSTRUCTIONS TO THE PROVIDER: The client is requested to read and sign the client rights portion of this form. The provider is required to inform each client of sections I-VIII of this form and the purpose for each, requesting the client initial each applicable section.

Client Initials

I. SOCIAL SECURITY NUMBER DISCLOSURE

I hereby agree to provide my social security number(s) to the Florida Department of Children and Families(DCF)/Refugee Service Program, though I understand I am not required to do so under the law. I further authorize the Florida Department of Children and Families/Refugee Services Program to use my social security number(s) for identity, income, employment and eligibility verification, as well as other purposes related to the administration of DCF programs.

II. SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS (SAVE) DISCLOSURE

I hereby authorize the release of Department of Homeland Security data pertinent to my immigration status to the Florida Department of Children and Families/Refugee Services Program and the Skills for Academic, Vocational, and English Studies (SAVES) Program to access federal public benefits and/or Refugee Services-funded services.

III. PROTECTED HEALTH INFORMATION (PHI) DISCLOSURE

I hereby authorize the release of my PHI to the Florida Department of Children and Families/Refugee Services Program for the purpose of determining eligibility for services or special exemption from program requirements.

IV. FINANCIAL INFORMATION DISCLOSURE

I hereby authorize the release of my financial information to the Florida Department of Children and Families/Refugee Services Program for the purpose of determining eligibility for services, employment outcomes and/or economic statistics.

V. EMPLOYMENT OUTCOME DISCLOSURE INFORMATION

I hereby authorize the release of my employment information to the Florida Department of Children and Families/Refugee Services Program, for the purpose of verifying employment and determining the outcome of employment services. This data may include but is not limited to, Employee Information (Name, Date of Birth and Social Security Number), Employer Information, Employment Information (Job Title, most recent Start Date, and Termination Date, if applicable), and Salary/Benefits Information (Rate of Pay, Average Hours per Pay Period, Wages, Access to Health Insurance, etc.).

VI. CONTACT INFORMATION DISCLOSURE FOR CONDUCTING A SURVEY

I hereby authorize the release of my contact information: Full Name, Local Address, Cell/Home Phone Number, and Email address to the vendor approved by the Florida Department of Children and Families/Refugee Services Program for the purpose of conducting a survey to rate my refugee experience and generally assess refugee needs.

VII. CONTACT INFORMATION DISCLOSURE FROM ADULT EDUCATION SERVICE PROVIDERS

I hereby authorize the release of the following information: Full Name, Local Address, Cell/Home Phone Number, Email address, Adult Education test scores, Documentation of Vocational Program Completion, and ESOL level by the Florida Department of Children and Families/Refugee Services Program and the Refugee Services funded Adult Education provider to the Refugee Services funded Employment service provider so they can contact me to explain the employment and vocational training I might be eligible to receive.

VIII. CONTACT INFORMATION DISCLOSURE FROM EMPLOYMENT SERVICE PROVIDERS

I hereby authorize the release of the following information: Full Name, Local Address, Cell/Home Phone Number, Email address, and Test scores, if applicable, by the Florida Department of Children and Families/Refugee Services Program and the Refugee Services funded Employment service provider to the Refugee Services funded Adult Education provider so they can contact me to explain the educational services I might be eligible to receive.

CLIENT RIGHTS

- I have the right to revoke this authorization at any time by writing to the Florida Department of Children and Families/Refugee Services Program and the Skills for Academic, Vocational, and English Studies (SAVES) Program.
- I understand that signing this authorization is voluntary and my treatment, payment, enrollment, or eligibility for benefits is not contingent upon my authorization of this disclosure.
- I understand that information disclosed under this authorization may be re-disclosed by the recipient, and this re-disclosure may no longer be protected by federal or state law.
- The Florida Department of Children and Families/Refugee Services Program and the Skills for Academic, Vocational, and English Studies (SAVES) Program will give me a copy of this form upon my request.
- I understand that this authorization will expire at the conclusion of my Refugee Services eligibility period (5 years from date of entry) unless I specify a different date. My signature below indicates that I have read this form entirely, had the opportunity to ask questions, and authorize the use of a copy of this form for the disclosure of the information described above.

Client Name _____ Client Signature _____ Date _____

Provider Use Only: I have explained this form and its purpose to the client and the client has refused to sign.

Provider Signature _____ Date _____

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Date: _____

Miami-Dade County Public Schools
SAVES Program
School Name: _____
School Address: _____

School Fax: _____

SAVES Contact: _____

SAVES EMPLOYMENT REFERRAL

For Job Placement by Refugee Services Founded- Employment Provider

CLIENT INFORMATION:

NAME _____
SOCIAL SECURITY # _____ **Alien #** _____ **Phone #** _____
ADDRESS _____**CITY and STATE** _____ **ZIP**_____
INTAKE DATE _____
ESOL _____ **VOCATIONAL TRAINING** _____ **OTHER** _____
REFERRED TO SERVICE PROVIDER DATE: _____

LIST FOUR LOCAL PROVIDERS NEAR YOUR SCHOOL

Provider Name _____ Provider Address _____ Citi, State, Zip _____ Provider Telephone _____	Provider Name _____ Provider Address _____ Citi, State, Zip _____ Provider Telephone _____
Provider Name _____ Provider Address _____ Citi, State, Zip _____ Provider Telephone _____	Provider Name _____ Provider Address _____ Citi, State, Zip _____ Provider Telephone _____

TO BE COMPLETED BY SERVICE PROVIDER

Service Provider_____ **Address:** _____

Contact Person Name _____**Signature** _____

Telephone _____ **Enrollment Date** _____

REQUEST* BY CUSTOMER OR COMPANION WHO IS DEAF OR HARD OF HEARING FOR FREE COMMUNICATION ASSISTANCE

The Florida Department of Children and Families and its Contracted Client Services Providers are required to provide FREE interpreters or other communication assistance for persons who are deaf or hard-of hearing. Please tell us about your communication needs.

My name is _____.

☐ I want a free interpreter. I need an interpreter who signs in:

☐ America Sign Language (ASL) or an interpreter who speaks:

☐ Language: _____ Dialect: _____

☐ I want another type of communication assistance (check all desired assistance):

☐ Assistive Listening Devices ☐ Large Print Materials ☐ Note Takers

☐ TTY or Video Relay ☐ Assistance Filling Out Forms ☐ Written Materials ☐ CART

☐ Other (please tell us how we can help you): _____

_____

☐ I do not want a free interpreter or any other communication assistance. If I change my mind, I will tell you if I need assistance for my next visit. ***(Customer or Companion waiver of rights does not prevent the Department from getting its own interpreter or from providing assistance to facilitate communication and to make sure rights are not violated.)***

WAIVER OF FREE COMMUNICATION ASSISTANCE

☐ I do not want a free interpreter because _____.

☐ I choose _____ to act as my own interpreter. He/she is over the age of 18. ***This does not entitle my interpreter to act as my Authorized Representative. I also understand that the service agency may hire a qualified or certified interpreter to observe my own interpreter to ensure that communication is effective.***

Customer's or Companion's Signature:	Date:
Customer's or Companion's Printed Name:	
Interpreter's Signature:	Interpreter's Printed or Typed Name:
Witness's Signature:	Date:
Witness's Printed Name:	

*This form shall be attached to the Customer or Companion Communication Assessment and Auxiliary Aid/Service Record (form CF 761) and shall be maintained in the Customer's file.

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Date: _____

S A V E S

SKILLS FOR ACADEMIC, VOCATIONAL, AND ENGLISH STUDIES PROGRAM

STUDENT CONTRACT

PURPOSE OF SAVES: To provide free English language and job training to eligible refugees and asylees, 16 years and older, from all over the world.

BENEFITS: As a SAVES student, you are eligible for the benefits listed below, to be provided within the first sixty (60) months after arriving to USA or within sixty (60) months after granted asylum:

- ✓ English Classes/GED/ Citizenship Preparation
- ✓ Books/Instructional Materials (to be provided after 15 hours of student attendance)
- ✓ Vocational Training up to three (3) trimesters
- ✓ Employment Referrals
- ✓ Child Care Referrals (If needed)
- ✓ Course Advising/Attendance Counseling
- ✓ One Block Tuition Fee for AGE level/course

STUDENT RESPONSABILITIES:

1. Adult General Education (AGE) students who do not demonstrate documented progress in a course during any trimester, will have to pay the $35.00 block tuition fee/testing to repeat the course.
2. All SAVES students must demonstrate documented progress, or benefits can be denied.
3. Student is expected to have satisfactory attendance to receive/maintain benefits.
4. Student should inform instructor/s and SAVES contact(s) if he or she needs to be absent.
5. Student should inform instructor/s and SAVES contact(s) if he or she needs to withdraw.
6. Student is expected to return books/materials, if withdrawn.
7. SAVES ESOL students need to register early enough in the trimester to accumulate 70 hours of instruction to be post-tested and to continue receiving benefits.
8. SAVES ESOL students who are eligible for post-testing, and who do not post-test will be closed out of the program until they post-test and move to the next level.

I, _____ , have read the SAVES Student Contract and agree to comply with its requirements.

_____ _____

Student Signature Date

_____

SAVES Contact Signature

Rev. 09-18-2018

Disclaimer in English

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